Miami-Dade County Community Action Agency
Head Start/Early Head Start

Head Start Registration Requirements

Dear Parents (s):

The following items are needed before completing the Head Start/Early Head Start application process:

1. Your child's birth certificate. Children must be 3 or 4 years of age on or before September 1, 2010, or no more than five (5) years old after September 1, 2010.

2. Proof of parent's/legal guardian gross income for the past 12 months or the last calendar year. Documents include a signed Income Form Tax 1040, W-2 forms, pay stubs, pay envelopes, Unemployment Compensation, written statements from employers, or documentation showing current status as recipients of public assistance, Social Security Supplemental Income (SSI), TANF, or Child Support.

3. Picture identification of parent(s)/legal guardian – driver's license, state issued picture, employer issued I.D.

4. Proof of Dade County Residency.

5. If your child has a diagnosed disability, you must attach the Individualized Education Plan (IEP) or the Individualized Family Support Plan or IFSP. Disabled child are eligible for the Head Start Program on or after their third (3^{rd}) birth date.

Note: In order to ensure that your child receives proper care and attention, inform the Head Start staff during registration, if your child has any allergies, special medical or dietary needs, or other areas of concern.

All information returned to the Head Start/Early Head Start Program will be maintained in a confidential manner.

Miami-Dade County Community Action Agency
Head Start/Early Head Start

Early Head Start Registration Requirements

Dear Parents (s):

The following items are needed before completing the Head Start/Early Head Start application process:

1. Proof of pregnancy – Doctor's note.

2. Proof of age - child's birth certificate.

3. Proof of family gross income for the past 12 months or the last calendar year. Documents include a signed Income Form Tax 1040, W-2 forms, pay stubs, pay envelopes, Unemployment Compensation, written statements from employers, or documentation showing current status as recipients of public assistance, Social Security Supplemental Income (SSI), TANF, or Child Support.

4. Picture identification of parent(s)/legal guardian – driver's license, state issued picture, employer issued I.D.

5. Proof of Dade County Residency.

6. If your child has a diagnosed disability, you must attach the Individualized Family Support Plan or evaluation report (IFSP). Disabled child are eligible for Early Head Start (0-3 years old) and Head Start on or after their third (3rd) birth date.

Note: In order to ensure that your child receives proper care and attention, inform the Early Head Start staff during registration, if your child has any allergies, special medical or dietary needs, or other areas of concern.

All information returned to the Head Start/Early Head Start Program will be maintained in a confidential manner.

Miami-Dade Community Action Agency
Head Start / Early Head Start
Family Information

Primary Adult Name: _____ Birthday: _____

Eligible Child Name: _____ Birthday: _____

General Information:

Living Address:	City	State	Zip	County

Mailing Address (if different):	City	State	Zip

Phone Number	Home, Work, Cell, etc.	Primary	Notes
		☐	
		☐	
		☐	

Number in Household _____ (Living with Child) Num. in Family _____ (Supported by the income of parent or guardian) Total Num. of Children _____ Num. Age 0-3 _____ Num. Age 4-5 _____

Parental Status:	Primary Language at Home:	Center Applying for:
☐One ☐Two		

Family Income – Time period income based on: ☐ Previous 12 Months ☐ Last Calendar Year

TANF ☐Yes ☐No ☐Formerly SSI ☐Yes ☐No WIC ☐Yes ☐No WIC ID _____

Income Source		Frequency
Non-Agricultural Earned Income (i.e. wages, tips)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Agricultural Earned Income (i.e. wages, tips)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Public Assistance, Welfare (i.e. TANF, AFDC)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Social Security Pension / Retirement		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Supplemental Security Insurance (SSI)		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Foster Care/Adoption Subsidy		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Unemployment Compensation		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Child Support/Alimony		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month
Other Unearned Income		☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Annually ☐ Twice a month

Income Notes:

Emergency Contacts:

Name:_____ Relationship: _____

Address:_____ City:_____ Zip: _____ Phone #: _____ Phone #: _____

Name: _____ Relationship: _____

Address:_____ City:_____ Zip: _____ Phone #: _____ Phone #: _____

Medical / Dental Providers:

Doctor: ☐ Yes ☐ * No * (Staff Use Only) Referred to:_____ Date: _____ Referred by:_____

Doctor Name:_____ Address:_____ Phone #:_____

Dentist: ☐ Yes ☐ * No * (Staff Use Only) Referred to:_____ Date: _____ Referred by:_____

Dentist Name:_____ Address:_____ Phone #:_____

Miami-Dade Community Action Agency
Head Start / Early Head Start
Family Member Information

Primary Adult:

Last	First	Middle	Birthday	Gender

☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Highest Grade Completed:_____

Employment Status:
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time& Training
☐ Retired ☐ Disabled
☐ Training or School
☐ Seasonally Employed
☐ Unemployed

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Latino Origin

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:_____
☐ Poor ☐ Moderate ☐ Proficient

Secondary Adult:

Last	First	Middle	Birthday	Gender

☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Highest Grade Completed:_____

Employment Status:
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time& Training
☐ Retired ☐ Disabled
☐ Training or School
☐ Seasonally Employed
☐ Unemployed

Race:
☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Latino Origin

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:_____
☐ Poor ☐ Moderate ☐ Proficient

Other Family Members (Supported by the income of parent or guardian):

Adult/Child	Last	First	Birthday	Gender	Relationship

Application/ Referral Source:

☐Child Development Services ☐Child Welfare Agency ☐Community Outreach ☐Court Ordered Referral ☐Department of Children & Families ☐Disability Program ☐Early Head Start ☐Family/Friend ☐Flea Market ☐Former Parent ☐Hospital/Health Clinic ☐Healthy Start ☐Hotline ☐Public Housing ☐Public or Private Non-Profit Organization ☐Public Schools ☐Resource & Referral Agency ☐Self Referral ☐South Florida Workforce ☐Unemployment ☐WIC ☐Youth Fair ☐ Other (specify):_____

Verification:

I certify that the information provided in this application package, and the proof of income provided for enrollment eligibility, is accurate and truthful to the best of my knowledge.

Parent or Guardian Signature: _____ Date:_____/_____/_____

Parent or Guardian Print Name: _____

Miami-Dade Community Action Agency
Head Start / Early Head Start
Eligible Child Information

Eligible Child:

Last	First	Middle	Preferred / Nickname	Suffix

Birthday	Gender ☐ M ☐ F		Alternate ID

Race:

☐ Asian
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity:

☐ Hispanic or Latino Origin

☐ Non-Hispanic or Latino Origin

Nationality:_____

English Proficiency:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Other Language Spoken:
☐ None ☐ Poor ☐ Moderate ☐ Proficient

Primary Adult Relationship to Child: ☐ Custody

☐ Foster* ☐ Grandchild * ☐ Biological ☐ Adopted*
☐ Step ☐ Niece* ☐ Nephew *
☐ Other*
(specify)_____

Secondary Adult Relationship to Child: ☐ Custody

☐ Foster* ☐ Grandchild* ☐ Biological ☐ Adopted*
☐ Step ☐ Niece* ☐ Nephew*
☐ Other*
(specify)_____

*** Legal court documentation is required to enroll child.**

Is there a current Order of Protection or No Contact order which concerns this child? ☐ Yes ☐ No

Medicaid Eligibility:
☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible

Medicaid Number: _____

Insurance Number: _____

Other Health Coverage:
_____

☐ No Health Coverage

Referral completed to:

_____

Kidcare Application Completed Date:_____

Staff:_____ Date: _____

(Medical Provider): Does the child have an ongoing source of continuous, accessible medical care? ☐ Yes ☐ No

(Dental Provider): Does the child have an ongoing source of continuous, accessible dental care? ☐ Yes ☐ No

Assistive Devices Used: ☐Glasses ☐Contact Lenses ☐Crutches ☐Walker ☐Cane ☐Wheelchair ☐Braces ☐Hearing Aides ☐No Assistive Devices Used

Health Concerns: Yes ☐ No ☐

Describe: _____

Diagnosed Disability with IEP (HS) or IFSP (EHS): Yes ☐ No ☐ Date: _____ Diagnosed Disability with Professional Diagnosis: Yes ☐ No ☐

Family Circumstances:

Family Demographics: Place check ☑ in appropriate box	Yes	**No**	**Parental Status:** Place check ☑ in appropriate box	Yes	**No**
Documented Substance abuse			One Parent		
Documented Domestic Violence			Two Parents		
Parent education <8th grade			Foster Parent		
Teen Parent <17 years old			Guardian		
Homeless Length of time homeless: _____			**Family Services:** Place check ☑ in appropriate box		
Pregnant Women			Medicaid/Medicare		
Public housing resident			Food Stamps		
Parental Disability			WIC		
Transition from Early Head Start to Head Start			Public Assistance/ Welfare		
Working Parent			TANF/AFDC		
KIDCARE – Health Insurance			Supplemental Security Income (SSI)		
Court Ordered Referred			Foster Program Referred		

Miami-Dade Community Action Agency
Head Start / Early Head Start
Family Demographic/Eligibility Information
(Office Use Only)

1. Primary Adult Name _____ Birthday _____
2. Eligible Child Name _____ Birthday _____
3. Child's date of enrollment into program: _____ Child's date of entry into program: _____
4. Earned Income Annual Amount $_____ Unearned Income Annual Amount $_____
5. Verify Eligibility - Check which category of eligibility this child falls into:

☐ Income

- ☐ Below federal poverty guidelines
- ☐ Between 100-130% federal poverty guidelines
- ☐ Over income

☐ Public Assistance

☐ Homeless

☐ Foster Care

6. What documentation was used to determine eligibility

- ☐ Income Tax Form 1040 (last calendar year) W-2
- ☐ Public Aid / TANF-documentation
- ☐ Pay stubs
- ☐ W-2 (last calendar year)
- ☐ Grants/Scholarships/Financial Aid
- ☐ Unemployment
- ☐ Written statements from employers
- ☐ Foster care reimbursement
- ☐ SSI documentation
- ☐ Social Security
- ☐ Child Support
- ☐ Other

Documentation of no income: _____

Staff Income Verification signature (required):

I have examined the income documents checked above and certify that the child is eligible to participate in the program.

Staff Signature: _____ Date of eligibility verification:_____

Staff name printed:_____ Title:_____

Center Director Signature:_____ Date: _____